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Letters to the Editor. . .

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Letters to the Editor . . .

(Note: The Journal of the American Medical Association (JAMA) refused to print the following letter.

To the Editor:

In her recent article *(JAMA,* Oct. 21, 1992) Dr. Stotland attempts to argue that post-abortion trauma is a "myth" and factually "non-existent". Clearly, more unbiased and expanded empirical studies need to be conducted in this area before the issue can be satisfactorily resolved. I am not a trained psychiatrist. However, as a former biomedical researcher and present philosopher and bioethicist, I would like to suggest one possible source of Dr. Stotland's denial of such a trauma - i.e., the denial (by many of us) of the actual status of what it is that is aborted. It would seem that this is critical to any factual understanding of adverse reactions (however psychiatry would categorize them) several years after the abortion event. I applaud Dr. Stotland's desire to "bring the discussion into the scientific medical literature", yet there must be an unbiased effort to be truthful and consistent in acknowledging in that literature what are "facts" and what are "myths".

Many of us have been thoroughly convinced by the scientific (and the bioethics) literature itself (before the fact of abortion) that the human embryo or human fetus is either not a human being, or if it is, that it is not a human person.[1] If either is factually the case, the decision of a woman to abort or not to abort her unborn child is *a priori* made considerably more justifiable and "rational". Elaborate scientific arguments have been flooding the biomedical literature for some years now, positing such scientific claims as: the human embryo or human fetus is just a "blob" or piece of the mother's tissues; that all of the genetic information specific for a human being is not present at fertilization; that human embryos can give rise to teratomas or hydatidform moles and therefore are not "human";[2] that all of the cells from the 5-6 day embryo trophoblast layer are discarded after birth and therefore it is really a "pre-embryo", that totipotent cells can each develop into later individual human beings, and that twinning can not take place after 14 days — and therefore the early human embryo is not a true "individual", and therefore not a true human being yet;[3] that full differentiation is completed by 14 days;[4] and that true "personhood" is not present until "brain-birth", i.e., the formation of the nerve-net, neocortex or whole brain integrating system.[5]

If such "medical facts" (and others like them) were actually true, it is small wonder that not only young teen-age girls and younger women, but also boy friends, husbands, parents, grandparents, priests, ministers and counselors, physicians, nurses, researchers, public policy makers, Supreme Court Justices — and yes, even psychiatrists — have bought into such "scientific" claims which are really, themselves, in fact "myths" and "non-existent." Surely such scientific misinformation has bolstered at least temporarily their firm convictions that the early human embryo or human fetus is not really a human being or a human person, and therefore disposable or insignificant in contrast to the autonomous rights of "women who become pregnant under problematic circumstances." Unfortunately, these "scientific facts" in the biomedical literature are all incorrect; yet I do not hear Dr. Stotland calling for an objective purging of these "myths" from the biomedical literature in the name of scientific accuracy and the physician-patient relationship.

To determine if the human embryo is a human being, all one has to do is count the number of chromosomes under a microscope, and observe the functions and activities which are present immediately after fertilization. The real scientific facts are the following.

The early human embryo and human fetus is not a "blob" or piece of tissue of the mother. When the 23 chromosomes of the sperm and the 23 chromosomes of the ovum are combined (by the end of fertilization), a new, unique living individual with 46 chromosomes (the number and quality specific for the human species)[6] is formed. Although this means that the human embryo is a human being, the chromosomal make-up of the human embryo and fetus is qualitatively different from that of either the mother or the father. That is, the genetic identity of the human embryo is different from the genetic identity of the tissues of the mother. The embryo is already a male or a female; immediately specifically human enzymes and proteins are formed; specifically human tissues and organs will be formed.[7] Virtually all of the genetic information the human being will ever have or need is present immediately at fertilization. No genetic information is gained or lost throughout development — only the use of some information is lost through mechanisms such as methylation.[8] This original genetic information "cascades" throughout the course of human development, determining later molecular information, tissue and organ formation;[9] and it includes the genetic information needed for differentiation,[10] totipotency (which is quite normal) and all of the processes of embryogenesis — sometimes even twinning. Entities such as teratomas and hydatidiform moles do not arise from genetically normal human embryos, but from abnormal embryos to begin with (e.g., dispermy).[11] All of the cells from the trophoblast layer are not all discarded after birth, but many from the yolk sac and allantois are incorporated into the embryo-proper as the early blood cells and the primordium of the primitive gut, and in the human adult as the median umbilical ligament and blood cells.[12] Twinning is possible after 14 days, e.g., with fetus-in-fetu and Siamese twins.[13] And there is no scientific physiological basis for a valid parallel between "brain death" and "brain birth", sentience or self-consciousness.[14] Full human development is not complete until after 20 years of age,[15] and full brain integration and the actual exercising of "rational attributes" are not present until several years after birth.[16]

Thus any arguments about physiological "preconditions" for either sentience or rational attributes are themselves arguments from potentiality, and actually depend physiologically on the precondition of the single-cell human zygote itself. If either actual sentience or rational attributes are the rationale for human "personhood", then newborns, young children, Alzheimer's and Parkinson's patients, alcoholics, drug addicts, the mentally ill and depressed (to name but a few) are not "persons" either, and thus, by the same logic, could be "disposed of".

The position that the early human embryo and human fetus is not a human being or a human person, then, is itself scientifically and medically a "myth". Such incorrect medical information should be brought out into the "light" of professional scientific scrutiny as well as any information concerning the "myth" of post-abortion trauma. Yet how many physicians, or psychiatrists, are willing to "provide [this] sound scientific information [to their patients] to help them make informed decisions about health issues"? Not many.

Yes, Dr. Stotland is correct to note the increase in the conflict concerning abortion, especially since the *Roe v Wade* decision. But she implies that religious and personal opinions which reject abortion are factually misplaced and are being imposed on women who have the absolute autonomous right to choose whatever they want in regard to their unborn child. She also implies that these irrational (because personal and/or religious) claims about post-abortion trauma are hampering the physician's and the psychiatrist's role to "counsel, advocate for, and treat individual patients on the basis of medical knowledge and in the patient's best interest".

Yet Dr. Stotland refuses to consider that perhaps some personal opinions and some religious convictions are rooted in non-relative, objective facts. For example, the human embryo and the human fetus *are* human beings. Perhaps the correct embryological facts are obtained years after the abortion. Or perhaps the woman eventually puts two + two together in some other way. That correct information, coupled with a religious commitment to respect all innocent human beings (regardless of their race, sex, nationality — or size) could conceivably trigger such a "traumatic" event in the mother who has previously naively aborted what she thought at the time was just a "blob" of her

own tissue. If she has also donated her aborted unborn child for fetal tissue transplant research, perhaps she could also come to the realization of another medical "fact" — that her fetus was *not dead* or anesthesized when his or her brain cells were removed for such "therapy". These medical "facts" should also be constitutive of any realistic physician-patient counseling — and yet they are not.

A woman could also come to the gradual realization that a woman's — or any other human being's — "pure autonomy" is also a "myth". Certainly the field of bioethics is beginning to come to grips with that dialogue. No one — male or female — has an absolute right to choose anything, just because conditions are difficult or a mistake was made. Our choices are always qualified; and we must all live with the consequences of our "choices". Again, Dr. Stotland refuses to consider that she is — in fact — medically treating *two* patients when she is counseling about abortion — the mother *and* her unborn child. If there is such a thing as post-abortion trauma, to counsel for abortion could in the long run be counter-productive to the "best interests of the mother" — not to mention the best interests of her unborn child — who *is* a human being right from the start.

Finally, I respect Dr. Stotland's concern about what has come to be identified as a "woman's issue". I myself am a professional woman, and I know perfectly well that women have been the subject of serious and unjustified abuse and discrimination. However, this does not condone the current "rationalization" and legalization of everything and anything, simply because many women "want" it. Abortion is, in fact, ultimately an aggression against women. The sooner women acknowledge that fact the sooner more realistic counseling of women in "problematic" situations can be provided by physicians and psychiatrists alike. Dr. Stotland should not be so selective about which "facts" to explore in the biomedical literature. Nor should she be so quick to selectively accept as "facts" things which are in fact "myths".

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To the Editor:

There is a serious fault to Mark A. Johnson's argument in his article, "The Principle of Double Effect and Safe Sex in Marriage: Reflections on a Suggestion" *(Linacre Quarterly,* May 1993). The omission is not only curiously large, but undermines the foundation of his argument, namely, that the use of condoms to prevent disease transmission in marriage is morally wrong because the directly intended act is the same as in contraception. The directly intended act, according to Dr. Johnson, is blocking the deposition of semen into the vagina, which is the purpose of marital intercourse.

Dr. Johnson forgets that marriages are made up of two people, either of whom could

be infected with the AIDS virus. Indeed, Earvin "Magic" Johnson, the charismatic spokesman of the deplorable "Safe Sex" campaign, swears that he was infected by a woman. (I use the example of Arthur Ashe, another sports celebrity, to remind readers that even chaste, virtuous people are susceptible to the virus through a variety medical mishaps.)

How, then, do the principles of double effect apply to cases where the infected marriage partner is a woman? In these cases, disease prevention is pursued by preventing infected vaginal secretions from infecting penile skin. The directly intended goal in using a condom is thus not contraceptive. I propose that in these cases, the four principles of the double effect are met:

1. The directly intended object of the act —blocking virally infected vaginal secretions from penetrating penile skin — is not contradictory to moral law.
2. The use of the condom is intended to prevent infection of the husband by the wife, not the prevention of semen entering the vagina. The action of contraception is thus only indirectly intended.
3. The beneficial effect of not transmitting a fatal disease to the husband is at least as great a good as contraception is a wrong.
4. The beneficial and deleterious effects are both immediately related to the use of a condom.

My analysis of this problem leaves us with the tenuous moral position of saying that condoms are an acceptable means of disease prevention in marriages where the wife is infected with the AIDS virus, but not when the husband is infected. I hope that these remarks will add completeness to Dr. Johnson's remarks, as well as encourage further discussion of this important topic. Perhaps some other reader will be able to meld these two judgements into a simple, consistent, and universally applicable moral principle.

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